

Maine

Office of Substance Abuse

Technical Review Report:
Phase II—Assessment of the Opioid Treatment
Provider System

September 26, 2003

Prepared for
Division of State and Community Assistance
Center for Substance Abuse Treatment

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I. Introduction

A. PURPOSE OF THE TECHNICAL REVIEW

The State Systems Development Program (SSDP) was initiated by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance the viability and effectiveness of national and State-level substance abuse service delivery systems. The Technical Reviews project is one of SSDP's major components—an assessment of statewide systems that examines system strengths, identifies major operational issues, and measures progress toward meeting Substance Abuse Prevention and Treatment (SAPT) Block Grant objectives. The project focuses on providing SAMHSA, CSAT, and the States with a framework for effective technical assistance (TA), technology transfer, and new policy initiatives.

Two types of reviews are conducted through the Technical Reviews project: State-Requested Reviews, in which States identify their most pressing concerns and select one or more issues for indepth review, and Revised Core Elements Reviews, in which CSAT has identified certain issues for review.

The Maine Office of Substance Abuse (OSA) requested a Technical Review to examine statewide opioid treatment oversight and programming. This State-Requested Technical Review had the following objectives:

- To review the role of the State Methadone Authority (SMA), particularly its regulatory role and exercise of its oversight responsibility.
- To assess the treatment being provided in the opioid treatment programs (OTPs), including an appraisal of the extent to which the programs are employing best practices.

B. METHODOLOGY

The Technical Review is conducted by an independent contractor on behalf of CSAT. The intended audience is CSAT and the Single State Authority (SSA) responsible for delivering services supported by SAPT Block Grant funds.

The first step in the Technical Review process is the formation of the Technical Review team composed of specialists with expertise related to the issues under review. Prior to the onsite review, the reviewers examine documents provided by the SSA, other relevant agencies, and programs. Additional documents describing agency and program operations are obtained on site and reviewed either at that time or following the site visits.

Following the site visits, the reviewers conduct an exit conference with officials to discuss preliminary findings and TA recommendations. Following the site review, the reviewers complete the analysis of all documentation and generate draft reports that integrate the findings with the results of the site visits. The draft reports are submitted to CSAT and the SSA for review and comment. Final reports are then produced that incorporate the corrections and revisions agreed to by OSA, CSAT, and the reviewers.

The State-Requested Review for Maine was conducted in two phases:

Phase I—Systems Review of State Authority

This phase of the State-Requested Technical Review explores how the State is currently providing oversight and exercising regulatory authority for opioid treatment, and considers options for making this system more effective. Areas reviewed included:

- Role of the SSA and SMA
- Monitoring and regulatory processes, including client outcome data and reports from providers
- Position of opioid treatment in the overall continuum of care for substance abuse treatment
- Role of licensing/certification
- Impact of national accreditation
- Relationships with other agencies and organizations such as the Portland Police, the State Attorney General, and the State associations for pharmacists and for emergency medicine.

Data for this phase of the review were collected through interviews with key individuals, as well as review of available documents.

Phase II—Review of Clinical Practices in Methadone Clinics

Phase II of the State-Requested Technical Review will analyze the provider system for opioid treatment in the State. Information will be gathered from provider agencies on how opioid treatment services are being provided, the extent to which providers are employing best practices in their treatment, and how services might be enhanced. Areas that may be reviewed include:

- Program capacity and current utilization
- Client characteristics

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- Admissions process including requirements, assessment, and screening
 - Availability, access to, and utilization of auxiliary services including case management
 - Treatment issues, including treatment plans and progress notes, dosage levels, treatment of polysubstance abuse, and responses to positive urine tests
 - Options for abstinence and drug-free treatment
 - Staffing patterns
 - Client outcomes, including employment, criminal justice, and housing
 - Client satisfaction, including interviews with clients where feasible
 - Quality assurance systems, including diversion management
 - Data management capacity and reporting requirements

An interview protocol was developed to guide provider interviews. OTPs were visited to gather data for this phase of the review. In addition, selected substance abuse treatment programs were visited to gather additional perspectives on the interface between opioid treatment and other substance abuse treatment services.

Two reports will be prepared as a result of this two-phase review:

- Assessment of State Management and Oversight of Opioid Treatment
- Assessment of the Opioid Treatment Provider System

This report, Assessment of the Opioid Treatment Provider System, summarizes the findings of the second phase of the review.

C. GENERAL LIMITATIONS

The information presented in the Technical Review reports is based on analysis of the interviews conducted at OSA, treatment providers, and other Maine agencies and review of available documents. The scope and depth of the review are limited by the amount and quality of the documentation, the amount of time spent on site, and the depth and accuracy of the information provided in interviews by OTP representatives.

The findings in this Technical Review report do not constitute audit findings and should not be used for that purpose. The fiscal information included is based on data provided by the agencies reviewed.

The findings represent organizational development and compliance issues identified in the SAPT Block Grant (Catalogue of Federal Domestic Assistance Number 93.959), and they are intended to serve as the basis for TA developmental action plans to improve Maine's capacity to deliver the services required under the SAPT Block Grant. This report is intended solely for the use of CSAT, Maine, and their appropriate designees.

D. STATE REVIEW PARTICIPANTS

A list of the Maine Technical Review participants is presented in exhibit I-1. Appendix A provides a list of all Maine personnel interviewed during the Technical Review. Appendix B provides a list of acronyms relevant to Maine. The protocol used to gather information is included in Appendix C.

Exhibit I-1. Maine Review Participants

AGENCY NAME:	Office of Substance Abuse
LOCATION:	Augusta, Maine
DIRECTOR:	Kimberly Johnson
REVIEW PERIOD:	July 14–18, 2003
REVIEWERS:	Sigrid Hutcheson, Ph.D., Team Leader Lawrence Hobdy, M.S., Clinical Specialist Eugenia Curet, M.S., Clinical Specialist

II. Context of Opioid Treatment in Maine

A. EMERGENCE OF THE PROBLEM

In March and April of 2002, the news media began reporting “methadone deaths” in the greater Portland area. The increase in deaths appeared to be primarily related to the use of prescription drugs, especially those prescribed for pain, anxiety, and depression. The majority of the deaths involved narcotics including methadone, oxycodone, fentanyl, and others. (The Maine Drug-Related Mortality Patterns: 1997-2002. Marcella H. Sorg, RN, Ph.D., D-ABFA, and Margaret Greenwald, M.D. December 27, 2002) Although the deaths quickly became known as “methadone deaths,” it was not clear to what extent the deaths were actually caused by methadone, as opposed to being caused by some other condition or combination of drugs in individuals who were taking methadone. The deaths received widespread coverage in the local and national press. Press coverage also gave the message that large amounts of methadone were being diverted and sold to drug users. One of the sources of diverted methadone was reported to be patients who were receiving take-home methadone who were using part of their take-home dose themselves and diverting the remainder.

OSA initiated and supported a number of organizational, educational, regulatory, and legislative initiatives to respond to the crisis and to strengthen the opioid treatment system. OTPs were placed under extensive scrutiny and continued to provide methadone treatment to patients while responding to ongoing regulatory oversight from OSA, as well as substantial pressure from other external organizations. In June 2002, SMA sent a memorandum directing OTPs to be open 7 days a week (removing the options for clients to have Sunday take-home doses), restricting take-home privileges by requiring clients to be in treatment for at least 3 months before any take-home privileges would be allowed, and requiring State exception approval for any 14- or 30-day take-home privileges.

The report from Phase I of this State-Requested Technical Review (Assessment of State Management and Oversight of Opioid Treatment) details the responses made by many parts of the Maine community to address the issue of drug related deaths. This report assesses the status of the opioid treatment system.

B. CHARACTERISTICS OF OPIOID TREATMENT PROVIDERS IN MAINE

The current opioid treatment system in Maine is composed of four programs as shown in table II-1.

Table II-1. Current Opioid Treatment Providers in Maine

	Founde d	Organization	Parent Organization	Accredited	Current Census (Week of 7/14/03)
Acadia Narcotic Treatment Program, Bangor	2001	Not-for-Profit	Comprehensive hospital and community-based mental health and substance abuse program (Parent hospital in Bangor)	JCAHO	230
CAP Quality Care, South Portland	2001	For-Profit	Parent organization has three programs in two States	JCAHO	607
Discovery House, South Portland	1995	For-Profit	Parent organization has 13 programs in five States	CARF	472
Discovery House, Winslow	1998	For-Profit	Parent organization has 13 programs in five States	CARF	185

As table II-1 shows, all the Maine OTPs were founded in the past eight years. Three are for-profit organizations affiliated with parent organizations that operate in multiple States. All are accredited, two by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and two by CARF...The Rehabilitation Accreditation Organization (CARF). The census of the OTPs ranges from 185 to 607 with a total patient census of nearly 1,500 during the State-Requested Technical Review (July 14–18, 2003).

One valuable support for OTPs is monthly meetings of the Opioid Treatment Work Group which are hosted by OSA and include licensing staff and other invited guests, depending on the topics being discussed. These meetings have helped the four OTPs to share information, to cooperate in addressing issues of common interest, and to begin to operate as a coordinated system.

Facilities

Three of the OTPs operate in excellent facilities, with appropriate provisions for dispensing medication, and an environment conducive to treatment and rehabilitation. One OTP operates under very crowded

conditions, which somewhat constrains its ability to provide an attractive environment with attention to patient privacy. This OTP is actively engaged in finding a larger building that will provide more workable space. One OTP has designed a model environment for medication dispensing that demonstrates respect for patients and their rights to privacy.

Points of Pride

Directors and staff at all the OTPs were asked what about their operation they were the most proud of or felt was the most innovative. Some of their paraphrased responses included:

- ...we are a large tent that can serve many opiate dependent people who have many different goals, some incorporating abstinence and some not.
- ...take pride in seeing our patients change and get control of their lives.
- ...staff are committed and self-motivated to work to make our mission a living mission.
- We like our patients and treat them with respect.
- We met the national accreditation standards successfully.
- Our excellent physical facilities give a positive message to patients.
- ...have come through the last year of turmoil and intense media scrutiny successfully.

Staff at the OTPs expressed pride and satisfaction on achieving State licensure and national accreditation in the past year. Staff at the OTPs reported they have experienced intense public scrutiny and frequent criticism, and have struggled to carry out their missions in an environment where there was a great deal of opposition to their services. However, staff at the OTPs expressed optimism about their futures, and indicated plans for growth and improvement.

C. PATIENTS' CHARACTERISTICS

The population served by the four OTPs is for the most part Caucasian with a small percentage (about 3 percent) of Hispanics and Native Americans. Staff at the OTPs reported that 55 percent to 70 percent of the patients are residents of the communities where the OTPs are located. The remainder of the patients come from outside the local community from areas where there are no opioid treatment centers. It was reported that, up to a year ago, Oxycontin and Dilaudid were the main drugs of abuse for patients seeking treatment. Staff at the OTPs indicated that many sections of Maine are very depressed economically, and that many of the residents are engaged in high-risk occupations, such as

lumbering, fishing, harvesting blueberries, and digging clams, which often produce chronic injuries requiring ongoing treatment for pain. However, during the last year, there has been an emergence of heroin abuse, with staff at one OTP reporting that 70 percent of the new admissions are addicted to heroin.

The gender distribution among the patients seems to indicate an increasing number of females with addiction to opioids. Staff at one OTP reported that 50 percent of the patient population was female, while staff at the other OTPs reported the female population to be between 40 to 45 percent. Traditionally, in treatment programs nationwide, the typical ratio is one female for every two males.

Staff at most of the OTPs reported a median patient age of 25 to 34 years. Staff at two OTPs specifically reported that 28 percent and 18 percent, respectively, of their patient population were under 24 years of age; and the other reported a large number of patients in their early twenties. Staff at one OTP reported the highest number of patients to be between the ages of 23 and 26 (103) and 83 patients between the ages of 18 to 22. Staff at one OTP reported seven patients (one male and six females) between the ages of 18 to 20; another has 17 patients (five males and 12 females) between the ages of 18 to 20; and one reported having a patient who is 15 years old.

Although staff at none of the OTPs provided specific information regarding the rate of pregnancy among the female patient population, staff at one OTP reported having 30 pregnant patients during the last two years, and another reported having six patients who are currently pregnant. Staff at one OTP reported being actively involved in monitoring the prenatal care of its pregnant patients, while the others reported they referred patients for prenatal care.

The prevalence of human immunodeficiency virus (HIV) infection among the patient population is minimal; staff at only one OTP reported having an HIV infected patient. However, the rate of hepatitis C infection appears to be high. Staff at three OTPs reported the rate of hepatitis C infection among their patient population at 15 percent, 60 percent, and 70 percent, respectively. Staff at the fourth OTP did not provide any specific information regarding the prevalence of hepatitis C infection among its patient population. Several of the OTPs are testing for hepatitis C as participants in a local study being conducted by the Centers for Disease Control. However, the hepatitis C testing was reported to be focusing on patients who self-report intravenous drug use. Targeting only reported intravenous drug users will exclude patients that might have been infected through intranasal use, might have had a forgotten experience with intravenous use, or might have engaged in other high risk behaviors such as sharing razors. Therefore, the infection rates reported for the sample involved in this study may be low.

Although the comorbidity of mental health problems and substance abuse was reported as prevalent among the patient population, staff at only one OTP reported a specific number of patients (32) in treatment with co-occurring mental illness. Another OTP is directly involved in the referral and followup of their psychiatric patients within their larger institution.

III. Clinical Services

A. ADMISSION CRITERIA AND PROCESS

All OTPs seem to be in compliance with the Federal guidelines regarding admission criteria (i.e., verified continuous use of opiates for at least one year). OTP staff verify the history of opioid abuse through physical evidence, contact with the applicant's previous treatment facilities, and/or reports from physicians, families, and significant others. In addition, a drug toxicology screen is performed during the intake process.

Staff at the OTPs reported requesting exemptions from SMA for the admission of patients who were younger than 18 years old. In addition, staff at one OTP reported excluding persons with mental health illnesses who were not receiving psychiatric treatment.

The admission process varies. One OTP has a central intake unit where the staff is trained to do telephone screening; two of the OTPs have a combination of "walk-ins" and scheduled appointments; and the other OTP has a structured telephone screening which allows for the staff to do preadmissions and refer the applicant elsewhere if the applicant does not meet the admission criteria.

Although the State does not have a central registry for all the patients in opioid treatment, OTP staff try to prevent the possibility of the double enrollment of patients by immediately forwarding admission data to OSA (the file cannot be opened at OSA if the client is still open in another program). The patients also have to provide signed informed consent forms indicating they are not receiving methadone treatment elsewhere. All the OTPs complied with the required admission consents—treatment, payment, confidentiality, and program rules and regulations. One of the OTPs provides a written and oral presentation to the patient of basic information regarding infectious diseases, such as HIV, hepatitis C, and tuberculosis.

All patients approved for admission undergo a comprehensive intake process, which usually consists of the following: biopsychosocial history, drug toxicology screen, complete blood work (CBC, liver chemistry, syphilis), and tuberculosis screening. Staff at three of the OTPs reported offering HIV and hepatitis C testing upon admission.

During the intake process, prospective patients are provided with an initial orientation to methadone treatment and program rules and regulations. In addition, prospective patients are required to provide written signed consent to treatment.

B. TREATMENT PRACTICES AND PROCEDURES

Staff at all the OTPs reported and documented that they provide a thorough orientation to all new admissions during the first 30 days of treatment. During this phase of treatment, the emphasis is on dosage stabilization and adjustment to the treatment program rules and regulations. After the initial 30 days, two of the OTPs offer one counseling session per month, while the other two offer counseling plus an additional array of services.

One of the OTPs offers an array of treatment services both directly or through referral to other treatment units. Specifically, in addition to receiving methadone for their opiate addiction, patients have access to vocational services, individual and group therapy, as well as marital and family counseling. Patients at this OTP also have access to periodic special activities such as music therapy as a parenting education intervention and mental health services, and occupational therapy through referral to other treatment units.

Besides offering individual counseling, another OTP offers group therapy which consists of parenting groups, 12-step, and lifestyle group work for behavioral changes. This OTP also employs a family medicine practitioner, as well as a physician assistant, who both seem very much involved in the daily treatment services provided to patients. Some of the OTP staff interviewed indicated that they preferred to have more group counseling but that the patients were not responsive to group work. However, some of the patients who were interviewed indicated a desire for more group counseling.

The amount of counseling and ancillary services provided at OTPs might be correlated with the number of patients in the counselors' caseload, as well as the counselors' training and experience. For example, the two OTPs that offer only the minimum of one counseling session per month have the least trained and experienced counseling staff, and the counselors' caseload consists of 58 patients. However, the OTP that provides the most comprehensive array of services reports a counselor case load of 40 patients.

As part of this State-Requested Technical Review, the records of nine patients were reviewed. These records contained progress notes documenting monthly individual or group counseling sessions received by patients as required for Medicaid reimbursement. There was no evidence in the patient records that patients were receiving more than the monthly counseling sessions regardless of treatment plan objectives and/or complexity of life circumstances. In addition, there were routine nursing notes at two of the OTPs visited that documented dosage changes and other health related issues.

C. TOXICOLOGY ANALYSIS

The monitoring of illicit drug use through monthly toxicology screens is the practice at all the treatment centers. Although this practice of monthly screens meets the recommended Federal guidelines, monthly screens might miss the continued abuse of illicit drugs and the need for objective assessment of dosage stabilization, especially during the initial stages of treatment. Staff at most of the OTPs reported that

about 80 percent of the patients' toxicology reports showed no evidence of illicit drug use, which is atypically high for methadone programs. If the OTPs conducted more frequent urinalysis perhaps the results would be different. The OTP staff stated that positive results in the toxicology screens most often show the use of benzodiazepines. OTP staff reported a range of actions typically taken in response to a positive urinalysis, including counseling, reduction in take-home privileges, and increase in methadone dosage. Staff at one OTP indicated that they attempt to use urinalysis as a clinical tool and not as a punitive measure. A patient interviewed at one OTP reported knowledge of several instances in which the patient or friends had been "using" the day before a random urine test and yet were told that the urine test was negative.

D. DOSING PRACTICES

All the OTPs initiate methadone maintenance treatment by starting with a dose of 20–30 milligrams of methadone. During the initiation phase, the patient's stabilization process is monitored by the nursing staff and the dosage is increased incrementally as needed. OTP staff reported that the nursing staff have standing orders for the total amount they can increase a patient's dosage without a new doctor's order. The standing orders vary from 60 milligrams of methadone at one OTP to 300 milligrams at another.

The average dosages of methadone at which patients have stabilized at the OTPs varied. Staff at one OTP reported a range of 120–250 milligrams and staff at two others reported 110–120 milligrams and 20–300 milligrams, respectively. Staff at a fourth OTP reported an average dosage of 259, with a small number of patients (10) receiving doses between 400–800 milligrams. It should be noted that this OTP has a large number of patients between the ages of 40 to 64 (116). The age of these patients suggests they may have long-term addiction to opiates with a physiological need for higher dosages of methadone. The OTP that reports higher dosage levels for some patients has been conducting research comparing long-term outcomes for patients on higher dosages to outcomes of a control group on lower dosages. The reported clinical findings indicate that a small number of patients (approximately 6–10 percent) required doses over 300 milligrams and, when patients received the higher doses, the number of positive urine screens were significantly reduced. (Marc Schinderman, Presentation at AATOD Conference - EUROPAD Section, 4/13/03, Washington, DC). While some clinical evidence supports the higher dosage levels, the rest of the OTPs and the community at large appears to be somewhat doubtful that these dosage levels represent standard best practices.

The process for approval of take-home medication seems to be the same for all OTPs and to follow the SMA memorandum of June 2002. Compliance with the program's rules, as well as absence of illicit drug use, are the major criteria for approval of take-home medications. Any request for more than 13 take-home doses is sent to SMA for approval. OSA has continued to be conservative in decisions about extending take-home privileges as part of the overall effort to reduce diversion potential.

E. PROCEDURES TO PREVENT DIVERSION OF MEDICATION

Staff at all the OTPs reported having standard mechanisms in place to prevent diversion of methadone. Most OTPs utilize the following measures to prevent diversion of methadone among the staff:

- Only the medical and nursing staff is allowed into the dispensing area.
- No purses, bags or any other articles in which the methadone could be placed are allowed in the dispensing area.
- Spillages of medication are witnessed by at least two staff members.
- Destruction of unused methadone is also witnessed by at least two staff members.

To prevent diversion of methadone among the patients, the following procedures are in place:

- All patients are provided with education regarding methadone intake and security, as well as information about the risks of diversion or sharing medication.
- OTPs adhere to strict criteria for take-home medication, including absence of illicit drug use.
- All the OTPs have call back procedures for the patients that have take-home medication privileges.
- Any informal information regarding diversion of medication is taken seriously and is thoroughly investigated.

F. SERVICES FOR SPECIAL POPULATIONS

Successful opioid treatment depends on engaging patients in treatment and on addressing any special needs each patient has that could become barriers to successful treatment. Groups that generally exhibit special needs include women, pregnant women, parenting women, homeless patients, and young patients who do not have histories of long term opiate addiction. With the exception of some accommodations for pregnant women, specific services for these groups were not evident at the OTPs visited.

Women's Services

In general, the OTPs do not have gender-specific treatment services for women. The medical services are generic, consisting of an initial physical examination, followed by annual medical check ups. There

are no provisions for annual gynecology examinations, Pap smears, breast examinations, mammograms, or bone density testing for older women. In addition, there was no evidence that services were being provided regarding domestic violence or issues of sexual abuse.

Services for Children

Treatment interventions for children could be a valuable component of treatment for patients with children. The Technical Review team observed children accompanying their parents at all the OTPs. Children of OTP patients are generally considered to be at risk for substance dependence across generations. In addition, the use of drugs by pregnant women may impact the development of their children. Because many of the children may have spent much of their childhood in multiple out-of-home placements while their parents were not able to care for them, these parents may not have had the opportunity to develop strong parenting skills. Adding services to address these needs would provide important support to parents who are receiving opioid treatment.

Adolescents

Staff at all four OTPs reported that they are seeing an increasing number of patients addicted to opiates in their early to mid-20's and a growing number in their late teens. OSA has a specific approval process for admitting youths 18 or under to opioid treatment, but none of the OTP staff indicated that they had developed specialized approaches for treating these young patients. In addition, none of the OTP staff indicated they had any provisions for educational or vocational services for these young patients.

Homeless

Patients entering OTPs who are homeless may find it very difficult to engage successfully in treatment. Patients who have no permanent housing or who are living with other addicted individuals or living in buildings where drugs are used frequently will require special services to address their needs. None of the OTP staff reported any formal arrangements to assist patients with their housing needs. The Technical Review team visited a half-way house/therapeutic community that has developed a collaborative relationship with a nearby OTP and will admit individuals receiving methadone treatment.

Mentally Ill Chemical Abusers

Staff at all OTPs reported that there is a significant number of opioid treatment patients who have a co-occurring mental illness. OTP staff reported that the public sector mental health system in Maine is overburdened and ill-equipped to deal with patients enrolled in OTPs. OTP staff reported that, when referring their patients to mental health services, there is a waiting list and it is generally difficult to get their patients mental health services. Two comprehensive behavioral health treatment centers visited by

the Technical Review team offer a full-range of treatment services and integrated substance abuse and mental health services are most likely to occur in these centers. These systemic issues will need to be addressed jointly by OSA and the mental health agency.

G. PATIENT PERSPECTIVES ON TREATMENT

Patients (selected by the agency) were interviewed at each of the four OTPs visited by the Technical Review team. A Technical Review team member interviewed each patient for 45–60 minutes and then reviewed the patient's record. A total of nine patients were interviewed, seven females and two males, ranging in age from 23 to 57. All seven of the female patients had children, and three had one or more children below the age of five. Seven of the patients reported a history of combined heroin and/or synthetic opiate intravenous drug use along with other synthetic opiates, while two reported they had never used opiates intravenously. One patient had used prescription opiates exclusively. All patients who were polysubstance abusers reported that they used alcohol and/or other illegal drugs along with opiates.

All the patients interviewed were employed. Their employment ranged from earning minimum wage to being owners of their own businesses. Four of the patients were being actively treated for a co-occurring mental health condition. One patient was receiving mental health treatment within the same agency where opioid treatment was being provided. The remainder were receiving services from community public agencies. Three of the patients had been involved in opioid treatment at other facilities, two in neighboring States and one at another OTP in Maine.

All patients interviewed were generally pleased with their treatment, and indicated they felt their counselors were helpful. Patients reported that they felt comfortable calling their counselor to discuss issues or requesting time with their counselor during clinic visits when monthly counseling sessions were not scheduled. All indicated that they felt that coming to treatment either saved their lives or prevented jail or hospitalization for them. Eight of the nine patients supported increased use of group therapy in their treatment.

Two of the patients interviewed had 30-day take-home privileges prior to June 2002, when SMA sent a memorandum to all OTPs implementing more restrictive practices for take-home medication. At that time, 30-day take-homes were disallowed for all patients, and patients were limited to 14-day maximum take-homes and were required to be seen weekly by the OTP. The two patients who were on 30-day take-homes felt they were unfairly punished and inconvenienced by the changes. One patient had been in opioid treatment for a total of 10 years and reported having no unexcused missed counseling sessions, having negative drug screens, and being employed and supporting a family. The other patient reported having been in opioid treatment in two States and was traveling several hours each way to receive treatment. This patient reported having serious health challenges and yet had not

missed a counseling session, had a long history of negative drug screens, and was gainfully employed. In order for the patient to make accommodations for the changes in policies on take-homes and clinic attendance, the patient moved closer to the OTP so that the distance and her health challenges would pose less of a potentially serious barrier to treatment. Both patients stated that they would be supportive of rule changes that establish clear criteria that reward patients who are doing well in treatment with longer take-home allowances and fewer face-to-face counseling sessions. In addition, these two patients were supportive of clear rules about when those privileges would be revoked or modified.

IV. Clinical Management

A. SYSTEM CAPACITY

Staff at all OTPs reported demand for services that exceeded their service capacity. Patients reported having to call OTPs repeatedly before being admitted. In some cases, patients reported that the demand as they perceived it was very high and was not being met by the current system capacity. In addition, patients reported that there are a number of potential patients who have given up on attempts to be admitted to OTPs because of the wait, lack of availability of services in some parts of the State, and transportation issues that were a barrier to admission.

Staff at each OTP reported that their capacity was limited by space and number of counseling staff. Staff at three of the OTPs indicated the typical case load was 50–60 patients per counselor, while one indicated a case load of approximately 40. The mix of old and new patients, the rate at which new patients are added, and the support and supervision of the new counselors varies from program to program. Staff at one OTP reported maintaining a formal waiting list of approximately 100 individuals. This OTP was admitting only “priority population” patients—patients who are either HIV positive, pregnant, intravenous drug users, have Hepatitis C, or are considered medical emergencies. Staff at the other three OTPs reported having a process in place for managing individuals seeking admission when there is not a slot immediately available. These OTPs were admitting new patients in conjunction with hiring new counseling staff. One OTP is pursuing a move to another location in the same service area to acquire additional space to handle the increasing demand for services.

The total number of patients served at the four OTPs visited by the Technical Review team was 1,494 based on each program’s census on the date of the site visit (July 14–18, 2003). Estimates from three of the OTPs indicate that they will collectively increase their enrollments by 100–150 over the next 9–12 months. The fourth OTP did not give a specific estimate, but was continuing to admit new patients regularly.

At one of the OTPs visited by the Technical Review team, the staff reported that since increasing their capacity and putting the word out that they were admitting new patients, usually 12–15 patients appear at the three weekly time periods for “open admission” for patients who live locally. Two days per week are set aside for new admissions by appointment for patients who do not reside locally. Staff at the OTP reported that on average only 3 or 4 of the 12–15 patients who present for open admission three days per week will meet admission criteria and be admitted to treatment. The individuals deemed inappropriate/ineligible for admission are referred to other services.

The entire opioid treatment system is hampered by the lack of timely and accurate data on level of need. One estimate of need can be based on the OSA Annual Report for 2002 which reports that of the 14.4 percent of the total patients treated in 2002 for addiction to heroin and other opiates, 9

percent were not involved in methadone treatment. (Maine Office of Substance Abuse 2002 Annual Report. www.maineosa.org) It is not clear what type of treatment these opiate-addicted individuals were receiving, but many of them may have been appropriate for admission to an OTP. Staff at one OTP estimated that the people seeking methadone treatment are one third of the total population needing opioid treatment but suggested that this is probably a very conservative estimate of need. Both OTP staff and patients reported that one scenario that may have contributed to the methadone overdose deaths may have been patients who were admitted to OTPs who shared their take-home methadone doses with others who could not gain admission to treatment because of the lack of availability of services.

OTP staff identified at least two areas of the State where new opioid treatment clinics could/should be established to meet the growing demand in those areas. Staff opinions at OTPs were based on their knowledge of the number of patients from those areas who travel significant distances for treatment, expressed interest by community representatives in establishing an OTP, and anecdotal information from patients living in those areas.

All four OTPs were operating fairly comprehensive data management systems that had the capacity to provide reports based on client information and staff activities, as well as to track due dates for client services. One OTP appeared to use their information system for management decisions and planning. The others appeared to use information systems primarily for tracking and monitoring client progress and staff activity.

B. BARRIERS TO OPIOID TREATMENT

A number of factors constitute potential barriers for patients needing opioid treatment.

- The demand for treatment is high and the existing OTPs are all operating at or near capacity, so all OTPs have some constraints on how many new patients they can admit.
- Outside of the main population centers of Portland to Bangor, there are no OTPs available, so patients have to be willing to travel long distances 6 to 7 days a week. OTP staff report that one hour of travel time each way is considered the maximum that is workable for most patients. Some patients reportedly have to travel up to 3 hours to access services.
- There is a lack of public transportation or affordable transportation alternatives that patients can readily access. Patients reported that the two Medicaid transportation services in their area of the State had discontinued services. Therefore, patients who relied on that mode of transportation to access services had to make alternative arrangements.

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- The amount of traveling time required for patients to get to the OTPs sometimes prevent patients from availing themselves of any ancillary services that the program might offer.
 - Patients who spend significant amounts of time traveling to OTPs have limited time available for employment or for becoming engaged in programs in the community in which they live.
 - Lack of availability of childcare precludes some individuals from seeking treatment. The Technical Review team observed a number of young children accompanying their parents to OTPs.
 - The stigma associated with opioid treatment in community hospitals, mental health, substance abuse, and other social service agencies prevents patients from obtaining other needed treatment services.
 - Methadone treatment patients can not be admitted to the State psychiatric hospital and are not eligible for participation in the drug court. In both of these situations, patients have to choose between these options and seeking methadone treatment.

All these barriers limit the number of patients accessing opioid treatment services and may contribute to a higher dropout rate and lower retention rate. These issues may have to be factored into OSA's decisionmaking regarding performance indicators.

C. STAFFING

The typical staff configuration at OTPs is a program director, clinical supervisor, and nursing supervisor. These individuals oversee a staff of counselors and nurses who perform direct services for patients. In addition, each OTP is required to have a pharmacist to oversee pharmacy operations and prepare the take-home doses for patients. Staff at each OTP also reported having a medical director, usually working part-time. Qualifications of these medical directors who were both Medical Doctors (MDs) and Doctors of Osteopathy (DOs) included specialization in addiction medicine and family practice.

Counselor backgrounds vary across OTPs. In one OTP, all counselors have Master's degrees or are Licensed Alcohol and Drug Counselors (LADCs). In another OTP, all the counselors are Registered Alcohol and Drug Counselors (RADCs). In two other OTPs, the counselors are a mix of Licensed Clinical Social Workers (LCSWs), Licensed Clinical Professional Counselors (LCPCs), and RADCs. In general, OTP staff reported that recruiting and retaining counselors is an ongoing challenge. Many of the counselors are hired at the entry level, and receive inservice training to prepare them for work as an addictions counselor. Staff at one OTP reported a structured program for orienting and training new counselors. Clinical supervision ranges from that provided by an LCSW one day a week to full-time supervision by a Licensed Alcohol and Drug Counselor meeting supervisory requirements.

Nursing staff are also varied in background. One OTP has a nursing supervisor who is a Registered Nurse Certified (RNC), one has an Licensed Practical Nurse (LPN), one has a Registered Nurse (RN), and one is in transition between nursing supervisors. Nursing staff typically are primarily a mix of LPNs and some RNs.

Staff at one OTP reported a very stable staff with annual turnover at less than 2 percent. This OTP partially attributes this low rate to a good benefit package, as well as support for staff to pursue advanced education. Staff at the other OTPs all reported a higher level of staff turnover along with some difficulty in recruiting staff, especially nurses and counselors. The availability of higher paying job opportunities for nurses in other settings makes it difficult to recruit and retain nurses. Many counselors were reported to be hired with educational backgrounds of high school or Associates degrees and limited experience which places greater demands on the OTPs to prepare the new counselors for their responsibilities. OTP staff reported that they found it challenging to recruit and orient new counseling staff while also admitting increasing numbers of new patients.

D. TREATMENT OPTIONS

Opioid and other treatment providers visited by the Technical Review team discussed several options for expanding opioid treatment services to the growing population of patients who need such services. It appears that the State could consider developing a continuum of treatment options to meet the varied needs of those addicted to opiates.

Methadone Treatment to Abstinence (MTA)

There are a growing number of opiate dependent individuals between the ages of 17–25 who are early in their addiction and are not able to access opioid treatment because of limited space, geographic access limitations, and other typical barriers to treatment. A Methadone Treatment to Abstinence program might be suited to some of these younger opiate dependent individuals who have some identifiable support systems and are motivated by other than legal requirements. OTP staff reported that some of the research literature suggests that detoxification from methadone has a poor record of 1 year of abstinence for these younger patients. However, patients in these studies were typically not provided ancillary services and supports to assist them in improving their life circumstances. Several OTP staff suggested that an MTA program that provided intensive auxiliary supports might provide better results than a standard detoxification program for younger patients. OTP staff suggested a program that allowed for:

- A longer period of tapering toward detoxification (12–18 months)
- Vocational, educational, mental health, medical, and social service supports
- Enhanced case management
- Housing supports

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- Option to return to maintenance treatment if needed or requested.

This type of program may be a model that would be better supported by the non-opioid treatment system and the public sector in general.

In addition, one substance abuse treatment provider visited is already using methadone for detoxification and their experience could be used to develop a plan for longer term methadone detoxification to abstinence.

Opioid Treatment for Patients Receiving Other Treatment Services

Another option explored by some of the OTPs was providing methadone treatment to patients concurrently enrolled in another substance abuse treatment service or mental health service. A patient could go to the OTP to receive methadone and have methadone levels monitored, adjusted, and stabilized as needed. The patient would then also participate in a substance abuse treatment program or mental health program, depending on need. An enrollment waiver would have to allow patients to be dually enrolled in two different types of treatment programs. This strategy would open the possibility of OTP clients being able to receive other needed treatment services simultaneously with their opioid treatment.

Office Based Opioid Treatment (OBOT)—Twelve physicians in Maine have completed the training specified by the Drug Addiction Treatment Act of 2000 (DATA 2000) which allows qualified physicians to treat opioid addiction with Schedule II, III, and IV controlled substances, or combinations of such controlled substances. DATA 2000 allows qualified physicians to dispense and prescribe these medications in an office-based setting, so that opioid addiction therapy can be provided in the mainstream of medical practice. DATA 2000 requires special DEA registration for physicians and also limits the number of patients individual physicians are allowed to treat to 30 patients. Some OTP patients may opt in the future for OBOT. One of the 12 physicians, who was interviewed by the Technical Review team, reported rapidly increasing demand for OBOT, and suggested that physicians offering OBOT would very quickly reach the 30 patient limit.

E. QUALITY MANAGEMENT

Performance Indicators/Patient Outcomes

Staff at the OTPs indicated that patient outcomes are important indicators of the quality of services provided. However, OTP staff also acknowledged that some performance indicators, if not adjusted to take into account the particular characteristics of opioid treatment patients, may give the wrong impression of the quality of services provided. OTP staff also indicated that the patient outcomes expected for typical outpatient substance abuse treatment are not appropriate for patients receiving

opioid treatment on an outpatient basis. For instance, one program that serves a higher percentage of patients that must travel distances to access services could conceivably have a lower rate of retention and keeping appointments because of the barriers travel poses to access. Longer term patient outcomes that may be appropriate for OTPs include reduced involvement with the criminal justice system, improved employment, and stable housing.

OSA will need to work closely with OTPs to identify performance indicators and outcome targets that will accurately reflect the goals of good opioid treatment services. One consideration may be to have both program-specific and aggregate indicators and outcomes. This would allow for specific considerations such as patient mix, location, and census and also hold all OTPs to produce some basic outcomes for which all OTPs are held accountable. Those OTPs not meeting targets in each category would need to adjust their procedures and processes to achieve target goals or provide evidence that circumstances warrant reconsideration of the targets.

Patient Satisfaction

Each OTP visited had policies and processes in place to address patient satisfaction. All four OTPs conducted patient satisfaction surveys. The process for surveying patients and the number of patients surveyed varied from program to program. One OTP provided surveys to all patients interested in completing one. Other OTPs relied on surveying a percentage of the total census of patients. One OTP had instituted a Patient Advisory Committee to assist with soliciting patient input into service provision and improvement.

Staff at each OTP reported that assessing patient satisfaction is part of a larger quality improvement program. In some cases, the OTPs are also part of a larger parent organization quality improvement program. Staff at each OTP reported that information from patient surveys has been used to make patient-centered program improvements. For instance, one OTP utilized the information from patient surveys and interviews with patients to expand their weekend hours while another changed their scheduling format for admitting new patients based on patient feedback.

F. REIMBURSEMENT OPTIONS

All OTPs served patients whose services were paid for through a combination of Medicaid, self pay, and third-party insurance. The majority of patients were Medicaid eligible with self-pay a distant second source of payment. Medicaid regulations were expanded last year to include eligibility for single men, which made this group of patients eligible for payment for opioid treatment. Only a few patients were being funded through third-party insurance coverage.

Medicaid funding covers a patient's methadone dose, one hour of counseling per month, and one drug screen per month. Any additional counseling or drug screens must either be paid for by the patient or

covered as part of the services provided by the OTP. The bundled service package covered by Medicaid pays OTPs \$80.00 per week per patient. Three of the four OTPs billed Medicaid for the bundled services.

OTP staff acknowledge that their patients would typically benefit from additional services including mental health services, medical services, vocational and educational counseling, and case management. However, since the service rate covers only the required services, there is no financial incentive or reward for OTPs to provide anything beyond the basic service package.

The OTPs that did not bill Medicaid for the bundled services instead billed for services separately, including counseling sessions, drug screens, and psychiatric services. In discussing whether bundled or unbundled (billing for services separately) service billing would have a more favorable impact on the frequency and quality of counseling sessions (individual and group), staff at all three OTPs reported that unbundled billing offered the potential for getting increased benefits for a limited number of patients and enhanced revenues for the OTP from increased counseling sessions. However, these three OTPs were generally in favor of the bundled services package as being adequate for the majority of patients served.

Unbundling services would require a set of adjustments for OSA and for OTPs. Unbundled services would offer the potential for enhanced patient care, particularly for those patients who may require more intensive counseling services. The two instances where this might be most applicable would be for new patients during their first 90 days of treatment and for established patients who have problems that require more extensive therapeutic counseling support and case management. OTPs would have to consider the hours of counseling time that would be required to provide these more intensive services balanced against the current caseload. OTPs might have to reduce the standard caseload to give counselors time to continue to provide the basic services to the rest of the patients, while providing enhanced services to a few patients. In addition, the demands of more intensive counseling might exceed the qualifications, experience, and ability of some of the counselors.

While increased counseling, where appropriate and necessary, may have positive impacts on the quality of care provided, OSA would run the risk of escalating their Medicaid budget to unsustainable levels. Providing enhanced services to some patients could result in consuming resources to the point that the number of clients OSA was able to serve in OTPs would decrease.

OTPs are a combination of for-profit and not-for-profit organizations; therefore, there is no standard method for determining the cost of providing services. Although each OTP most likely has cost data available for internal management use, OSA does not have the benefit of that information. The Technical Review team did not gather financial information systematically from the OTPs. However, some information provided on factors such as salaries, benefits, rent, and other operating costs appeared to vary from program to program. An analysis of the unit cost of providing services at each OTP would assist OSA in determining the best funding strategies and in maximizing funding to provide services to as many patients as possible.

V. Progress and Future Directions

A. PROGRESS

Over the past year, OSA and OTPs have worked intensively to strengthen the opioid treatment system in Maine both by addressing some of the specific problems that may have contributed to the apparent overdose deaths and by taking a number of actions to enhance the opioid treatment system.

The State's capacity for treating opioid addiction was limited both in capacity and depth of experience. The opioid treatment provider system was new with few staff who were experienced in working with methadone patients, and many patients who were new to methadone treatment. Options for opioid treatment were limited both by capacity of individual OTPs and by geography and distances, which left many patients with addiction to opioids with no viable treatment options.

Having faced the crisis precipitated by overdose deaths, the opioid treatment system has experienced a challenging but very productive year. OTPs have begun working together as a system; are collaborating with OSA and BDS licensing unit; and are building stronger relationships with public officials, law enforcement, and, to some extent, with the media. Under direction of OSA, the Pharmacy Board, and the licensing unit, the OTPs are operating under stronger controls to reduce diversion. All four OTPs are fully licensed and passed national accreditation in the past year.

OTP patients have been systematically informed about the impact and potential of methadone and the risks to themselves and others of diverting their medication. Education has been provided to active drug users about methadone and the risks of casual use. Public knowledge about methadone has also increased. Media personnel and civic leaders are better informed, and legislators are seeking ways to use legislation to contribute to solutions. The substance abuse treatment community is participating in ongoing educational opportunities. Substance abuse treatment providers interviewed described how their thinking, and that of some of their peers, is becoming more positive regarding opioid treatment. The substance abuse treatment community is gradually beginning to accept opioid replacement treatment as valid treatment for opioid addiction.

B. FUTURE DIRECTIONS

Although progress has been made and the operation of the OTP system has been strengthened, one of the major lessons learned is that the OTP system will need to continue to evolve in order to respond to changing needs. Some of the areas identified during this State-Requested Technical Review that will be part of the continuing development of the opioid treatment system are:

Changing Patient Needs—The profile of opioid users is continually changing, and currently is including more heroin users, more women, and an increasingly younger patient population. Currently,

OTPs offer minimal services for specialized population groups. Meeting these emerging needs will require new programmatic efforts to shape treatment programs by moving beyond the standard model of dosing and monthly counseling.

Broader Range of Services—Many of the patients in OTPs need other substance abuse treatment services, as well as mental health services and the full range of social support services. Individuals with longer term addiction have severed many of their ties to support systems and will have less chance of successful treatment if those supports are not restored.

Ongoing Needs Assessment—Although no formal needs assessment data are available, staff at all four OTPs indicated that the demand for their services far exceeded their current capacity. Expansion is limited by facilities and space, by shortage of qualified staff, and by some concern about what size of operation is optimal for an OTP.

Treatment Options—The opioid treatment system in Maine will continue to change. New OTPs may wish to begin services in underserved areas of the State. New forms of treatment may be introduced including OBOT and other formats to meet needs of specific groups of patients.

Barriers to Treatment—The greater the barriers placed in the way of individuals seeking opioid treatment, the less the probability of their successfully engaging in long-term treatment. Patients seeking opioid treatment experience barriers including having to travel long distances daily, facing stigma regarding opioid treatment, experiencing opposition from substance abuse providers, and experiencing discrimination from the judicial system.

Staff Recruitment and Retention—Many of the staff interviewed demonstrated a high level of commitment and dedication. However, their jobs are demanding, and staff at three of the four OTPs reported some difficulty in retaining staff, as well as in recruiting qualified new staff. Staff at three OTPs reported regular hiring of new staff. The new staff, particularly counselors, frequently have limited education and little or no experience with opioid treatment and, therefore, need extensive inservice training. All the OTPs met the current staffing standards for licensing and accreditation. However, OSA may wish to consider moving toward requiring higher levels of qualifications for staff to enhance the quality of treatment services.

Performance Measurement—Staff at all four OTPs indicated that they are proud of their work and cited positive accomplishments, particularly achieving national accreditation. However, in order to demonstrate continued success of their treatment within the State, the OTPs will need to have clear and appropriate performance measures and outcomes toward which they are all working. OSA will be able to use their performance on these standards to document the success of their treatment.

Financing—One strategy for OSA to provide incentives to move the opioid treatment system in positive directions would be to consider financing options that include incentives to provide an enhanced package of services to patients with more extensive needs.

VI. Technical Assistance Recommendations

Table IV-1 on page 28 was completed by the designated State official responsible for advising CSAT on the State agency's TA needs, following his or her review of Draft 1 of the Technical Review report. The purpose of including this form in the Draft 1 Technical Review report is to help expedite TA planning and delivery by giving CSAT staff an early alert on the State's needs. However, CSAT recognizes that TA priorities can change over time. Consequently, the State may reorder its priorities or change the scope of its TA requests during the TA planning and implementation process. This final version of the Technical Review report includes updated information on the State's TA priorities and delivery timeframe preferences.

The following are more detailed descriptions of the TA recommendations for the Maine:

Hepatitis C Education and Treatment—The State of Maine could benefit from TA on providing consistent Hepatitis C education and treatment to all clients.

Ongoing Review of Appropriate Methadone Dosage Levels—The State of Maine could benefit from TA on ongoing review of appropriate methadone dosage levels.

Use of Toxicology Screens—The State of Maine could benefit from TA on the use of toxicology screens for the objective monitoring of illicit drug use and the appropriateness of dosages during the early stages of treatment.

Standards of Care for Women in Treatment and Their Children—The State of Maine could benefit from TA on the development of specific standards of care for women in treatment and their children that could guide OSA's strategic planning and implementation efforts based on the best practices.

Treatment Options for Adolescents and Young Adults with Opiate Addiction—The State of Maine could benefit from TA on treatment options for adolescents and young adults with opiate addiction.

Assessing the Changing Needs for Opioid Treatment—The State of Maine could benefit from TA on assessing the changing needs for opioid treatment statewide.

Alternatives to Standard Methadone Maintenance Treatment—The State of Maine could benefit from TA on treatment options as alternatives to standard methadone maintenance treatment to address unmet needs.

Staff Development—The State of Maine could benefit from TA for ongoing staff development, particularly for counselors.

Integration of Opioid Treatment—The State of Maine could benefit from TA on integrating opioid treatment with other substance abuse and mental health service programs.

Unit Cost of Providing Opioid Treatment Services—The State of Maine could benefit from TA to help determine the unit cost of providing opioid treatment services by program and statewide average cost in order to utilize this data as a strategic planning tool for system service enhancement.

Table IV-1. Maine TA Recommendations Summary

State's TA Priority Number	Technical Review Team's TA Recommendations	Report Section and Page	State's Preference for TA Delivery (Month/Year)
10	Hepatitis C Education and Treatment	II. p. 8	*
2	Ongoing Review of Appropriate Methadone Dosage Levels	III. p. 11	January 2004
3	Use of Toxicology Screens	III. p. 11	March 2004**
8	Standards of Care for Women in Treatment and Their Children	III. p. 13	**
7	Treatment Options for Adolescents and Young Adults with Opiate Addiction	III. p. 13 IV. p. 20	**
4	Assessing the Changing Needs for Opioid Treatment	IV. p. 17	December 2003
5	Alternatives to Standard Methadone Maintenance Treatment	IV. p. 19	*
9	Staff Development	IV. p. 19	**
1	Integration of Opioid Treatment	IV. p. 20	January 2004**
6	Unit Cost of Providing Opioid Treatment Services	IV. p. 23	*

* The State did not prioritize this TA recommendation.

** The State indicated that it may wish to combine these TA recommendations and address them in a conference.

Appendix A. Maine Interviewee List

Representative	Organization
Steve Cotreau, Program Manager	AP Quality Care
Stan Evans, MD, Medical Director	Recovery Center at Mercy Hospital
Scott Farnum, Substance Abuse Administrator	Acadia Narcotic Treatment Program
Steven Keefe, Medical Director	CAP Quality Care
Don Kent, Clinical Supervisor	Discovery House South Portland
Pat Kimball, Director	Wellspring Halfway Houses
Scot LeBlanc, Counselor	Discovery House Winslow
Lynn Madden, Vice President and COO	Acadia Narcotic Treatment Program
Dan Mahone, Program Director	Discovery House South Portland
Ted McCarthy, MD Chief, Behavioral Health	Recovery Center at Mercy Hospital
Paul McDonnell, CEO	Milestone Detox and Shelter
Linda McEnroe, Clinical Supervisor	CAP Quality Care
Chellie Morrison, Clinical Supervisor	Milestone Detox and Shelter
Deb Purrington, RN, Director of Nursing	Recovery Center at Mercy Hospital
Marc Shinderman, MD, CEO	CAP Quality Care
Mark Smith, Staff Nurse	Milestone Detox and Shelter
Nancy Tingley, Program Director	Discovery House Winslow
Burma Wilkins, Administrator, Behavioral Health	Recovery Center at Mercy Hospital
Lynette Wood, Nursing	Discovery House Winslow

Appendix B. Acronyms Relevant to the Maine Technical Review

BDS	Department of Behavioral and Developmental Services
CAP	Center for Addictive Problems
CARF	CARF...The Rehabilitation Accreditation Organization
CCDC	Certified Chemical Dependency Counselor
CSAT	Center for Substance Abuse Treatment
DATA 2000	Drug Addiction Treatment Act of 2000
DO	Doctor of Osteopathy
HIV	human immunodeficiency virus
JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
LADC	Licensed Alcohol and Drug Counselor
LCPC	Licensed Clinical Professional Counselor
LCSW	Licensed Clinical Social Worker
LPN	Licensed Practical Nurse
MD	Medical Doctor
OBOT	office-based opiate treatment
OSA	Office of Substance Abuse
OTPs	opioid treatment programs
RADC	Registered Alcohol and Drug Counselor
RN	Registered Nurse
RNC	Registered Nurse Certified
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SMA	State Methadone Authority
SPO	State Project Officer
SSA	Single State Authority
SSDP	State Systems Development Program